King County

VIA EMAIL: bobbam@dshs.wa.gov

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Susan N. Dreyfus, Secretary
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Post Office Box 45010
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Doug Porter, Director
Washington State Health Care Authority
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Dear Secretary Dreyfus and Director Porter:

Thank you for your letter of August 23, 2011 inviting feedback on potential approaches to the future purchasing of behavioral health and long-term services and supports for Washington's low-income populations. King County shares your vision of a future health system that improves quality, results in better health, and slows the rate of cost increases. We have a particular drive to assure fairness and justice in health care access, prevention, and treatment for our low-income residents who are served through publicly funded coverage or who are uninsured, and it is through that lens that we offer these comments.

In preparing this feedback, King County consulted with a group of local stakeholders known as the Health Reform Planning Team, which include representatives of the community behavioral health system, the Area Agency on Aging, community health centers, a safety net hospital system, a health plan, homeless services, consumer advocates, and foundations. Their thinking helped us shape our response, and we are looking forward to continuing to work with them in the future.

Summary of key points in this letter:

1. Principles we encourage the State to apply
    - Purchasing strategies that support true person-centered care
    - Purchasing strategies that incorporate accountability for individual-level and community-level outcomes
    - Purchasing strategies that build on the current strengths of the system

2. Our Vision
    - Care coordinated through person-centered health homes
    - Access to a range of culturally appropriate, integrated services & single point of accountability
    - A health care system that partners with housing, education, employment services, prevention, and communities
    - Shared responsibility across systems for achievement of clinical and social outcomes

3. Response to Options
    - Financial integration alone doesn't lead to clinical integration.
    - Each option offers benefits that advance our vision of integration as well as risks that might hinder that vision; no new process should be implemented until these risks are addressed.
    - People with serious mental illness, substance abuse disorders, and/or complex medical conditions require a well-coordinated and comprehensive array of specialized services and supports that must be addressed under any finance structure. Effectively addressing these populations will substantially reduce health care costs in our system
    - If all or most health purchasing is shifted to the Health Care Authority (HCA) via capitated managed care, solutions and regional partnerships will be needed to assure that enrollees with complex health and behavioral health services receive tailored care and that managed care plans don't cost-shift to counties and other systems
    - If purchasing continues through the Department of Social and Health Services (DSHS) via carve-outs, new solutions will be needed to achieve a single point of accountability for costs, quality, and outcomes, and new solutions that support and fund access to behavioral health services in community-based primary care will be required

1. Principles we encourage the State to apply

Before we share our input on the proposed options, we ask that you actively apply the following overarching principles in your deliberations on how best to organize the purchasing of health services for low-income people in our state:

1. **Be truly person-centered**. Purchasing approaches must be nimble enough to support true person-centered care, assure ease of access, and minimize complexity. We need a system that maximizes choice and allows clients to receive integrated medical and behavioral health care services *where a person chooses*. Financing options thus need to foster a system that allows both for behavioral health services to be integrated into primary care, and for primary care to be integrated into behavioral health. Being person-centered also means assuring that there is a single point of accountability for per capita cost, quality, and outcomes.

2. **Support shared responsibility for outcomes.** Purchasing strategies that consider "integration" to apply only to Medicaid-funded services won't achieve the "triple aim." There is a clear relationship between an individual's health status and the social and environmental conditions in which he/she lives. The role of local and regional partners in providing services such as outreach, housing, employment, education, public health, prevention, and criminal and juvenile justice demonstrate the need to build deeper partnerships with the Medicaid system and managed care plans so that we can be mutually supportive to each other. By working together creatively to build and enforce real chains of accountability across these systems, we believe that local counties and communities and the resources they invest in health and human potential can help "bend the cost curve" in the Medicaid program *and* at the same time achieve our goals such as reducing justice system costs and infusing proven prevention strategies into our communities.

3. **Build on the current strengths of the system.** The King County community has many partnerships in place that demonstrate how we have bridged systems to achieve better health for our low-income residents. Future purchasing strategies by the State should be structured to sustain and expand these efforts as we move to 2014 and the prospect of over 65,000+ new Medicaid enrollees from King County alone. For example, in the Mental Health Integration Program—originally piloted for Disability Lifeline clients and supported in part through the King County Veterans and Human Services Levy—we have broken down historic silos in the medical and behavioral health fields, designing a clinical integration model and reimbursement mechanism that allows for more early identification and intervention for behavioral health conditions in community health centers, and coordination with specialty behavioral health services. Creative integration has also occurred between our safety net housing and health systems, where, for example, we have developed and prioritized service-enriched housing for those with complex medical and behavioral health needs, resulting in cost offsets in multiple systems and a better life for the

individuals. The state must address how a move to managed care as the primary purchasing platform will support the sustainability of these essential partnerships.

In addition to the above principles, we ask that the State assure that changes in purchasing be coordinated with related initiatives such as the dual eligible integration design and the re-design of the children's mental health system. These initiatives have significant overlap with the same funding and populations, and it is important that timing and changes are aligned with the overall vision of health care integration. Additionally, the state should consider the timing of any changes in purchasing. Any potential transfer of financing should ensure that the current system is not disrupted and that needed changes in clinical workflows are in place and understood by affected clients and providers.

2. Our Vision

King County has developed an overall vision for health care integration and accountability. That vision is described below. We evaluated the various purchasing options with regard to the extent to which that option would assist or hinder King County in moving toward the stated vision.

King County Vision: An Accountable Health System for King County's Low-Income Residents – *For low-income residents of King County, the health system of the future will place clients at the center. Care will be coordinated through a person-centered health care home that provides for or assures a broad range of culturally appropriate, integrated preventive, medical, dental, behavioral health, and social services – with a single point of accountability. One's health care home will be embedded in a broader integrated system of care that includes access to an array of social supports including housing, employment, education, community, and other social services. Healthy community environments will encourage recovery and promote individual and community wellness. The entire system of care will be responsible for the achievement of clinical as well as personal goals of its population, and for managing costs. Proactive work with the payment, regulatory and information technology systems at the local, state, and federal level will help assure that they support and enable this vision.*

3. Response to Options

The sections below address the key risks and benefits of five options that you have proposed for the purchasing of behavioral health and long-term care services. The purchasing options described by the state do not offer any indication about the service delivery package or the amount of funding that would be available to provide services for this population. We evaluated each option with the assumption that adequate funding and services would be available within each option to meet the overall health and behavioral

health needs of the population. Looking to 2014, we assume a behavioral health benefit will be included as part of the "essential benefit" package.

Option 1
Option 1 proposes to continue the current financing structure, with purchasing for behavioral health and long-term services and supports remaining with DSHS.

Benefits

- Ensures greater access to a more comprehensive, specialized set of needed health and social supports for those with serious mental illness/substance abuse problems than is currently typically designed or available under traditional medical managed care plans.
- Builds on the strengths of the current system by maintaining a well integrated system of care at the local level that includes housing, employment, wraparound and other social supports for those individuals with the highest needs.
- Allows for the design of a broad range of services to prevent the use of more restrictive and expensive hospital, detoxification, and residential care including community crisis stabilization, community case management, rehabilitation and skill building, family and consumer education, assertive community treatment, peer support and other recovery oriented services.
- Provides a natural incentive to build partnerships and programs that offset cost shifting or other local system costs.

Risks

- Continues to keep certain silos in place such that accountability and care coordination challenges remain a significant issue.
- The carve-out model provides specialty services and limits access to only those that meet specific criteria known as the "access to care" standards. Except in limited initiatives, the current system does not allow for the provision of early identification and intervention services to prevent more serious illness and greater cost down the line.
- Does not easily allow for or provide incentive for a health home model of care.

Option 2
Option 2 proposes to enhance primary care coordination with integrated community supports by transferring the purchasing of a core set of behavioral health services to HCA while continuing the purchasing of a supplemental behavioral health package through DSHS.

Benefits:

- Recognizes and provides for specialized services for those with more severe mental illness or substance abuse problems, ensuring access to a broader range of services and supports that help maintain these individuals in the community.

- Provides increased access to care for individuals with less severe mental health or substance abuse symptoms, ensuring early identification and treatment to prevent more serious problems down the line (building on the successful Mental Health Integration Program).

Risks:

- Individuals do not fall neatly into categories of "at risk for institutionalization" or not and are likely to move back and forth in severity of symptoms, requiring a change in providers and/or plans if they get better or worse.
- Continues to maintain a bifurcated system of behavioral health financing and treatment and health care financing, posing challenges with care coordination and multiple points of accountability.

Option 3

Option 3 proposes to transfer all Medicaid behavioral health treatment and services purchasing to HCA and continue purchasing long-term services and supports and services for individuals with developmental disabilities through DSHS.

Benefits

- Recognizes the complexity of the long-term care and developmental disabilities clients and systems; HCA lacks experience with these populations and managed care plans may not have the needed level of expertise or models that will be adequate or safe for them.

Risks

- This option appears to further fragment the payment and delivery systems by transferring purchasing for Medicaid behavioral health services to HCA but not non-Medicaid funding and services. It also leaves long-term care and developmental disabilities purchasing with DSHS.
- Many individuals at the state psychiatric hospital are also recipients of the long-term care services. Right now, with purchasing under the same authority at DSHS, coordination between the two systems is strong and produces better outcomes for the individuals and reduces hospital costs. Splitting the purchasing could disrupt needed integration of care for this vulnerable group and also make primary care coordination more difficult.
- Individuals tend to move back and forth in eligibility and this could result in disruption of services and changing of providers and/or plans.
- This option is likely to hinder the ability to provide person centered care and will not allow for a single point of accountability.

Option 4

Option 4 proposes to conduct pilots of integrated financing and delivery through managed care and health home models throughout the state.

Benefits

- Allows for the ability to "test" different models and learn from other regions, providing opportunities to fine tune integration before taking it "to scale".

Risks

- There is significant variability in the populations and service systems across the state, making it difficult to apply a single model to all regions.
- A thorough analysis of the challenges and outcomes of the Snohomish County integration pilot would be necessary to ensure success of any pilot program.

Option 5

Option 5 proposes to transfer all health care related purchasing to HCA.

Benefits

- Allows for a single point of authorization and accountability.
- Opens up greater access to care for clients who do not qualify for behavioral services under the current access to care criteria. Creates a more population-based approach, helping assure that individuals are screened and treated early on and preventing more serious problems.
- Allows for a system that more readily supports access to care within the context of a primary care medical home, where the majority of the population is likely to first seek care for behavioral health issues or who present with physical conditions that have behavioral factors.
- Would help assure that people with behavioral health conditions and those in long-term care systems have a regular health care home and access needed preventive and primary care services.
- By having all services under one plan, it enhances the ability to coordinate and integrate services; more readily removes financial silos and technology barriers that can stand in the way of effective care coordination.
- Less confusion for clients who would experience less shuffling between different systems of care.
- A fully integrated system could more easily allow for the development of a single care plan that can be shared across providers involved in a person's care.

Risks

- May not adequately address access to the supportive social services such as housing, employment, and wraparound services, which are necessary to stabilize individuals with serious mental health, substance abuse, and/or complex medical conditions.
- Would likely increase the risk of cost shifting to other systems (such as hospitals and jails) as managed care organizations would not have the same incentives to serve the most complex individuals avoid costs to other parts of the system.

- Traditional medical managed care organizations may not have the capacity or skill to serve individuals with the most complex mental health and substance abuse issues leading to worsening of symptoms and increases in overall health costs.
- If populations with more complex behavioral health disorders are spread across multiple managed care plans, any given plan may not have incentive to develop or procure specialized programs for those enrollees – programs such as community crisis stabilization services, hospital diversion alternatives, and assertive community treatment.

Summary Comments
Regardless of whether the existing purchasing approach continues (Option 1) or whether purchasing is fully or partially shifted to the Health Care Authority, solutions will be needed to address the drawbacks and challenges that each presents.

If purchasing were to continue under DSHS, it is imperative that the systems design a way to increase care coordination so that there is a single plan of care, a single medication list, and a single problem list that is accessible to all providers that may be working with that individual, including a mechanism for "real-time" health information sharing. Second, the systems will need to create a mechanism that allows for and funds early identification and intervention for individuals who may be showing only mild or moderate symptoms, so as to prevent more serious and costly behavioral health problems down the line. Third, there would need to be a way to finance services for those with serious behavioral health disorders who seek services in the primary care system (i.e., we must recognize that for various cultural, stigma, and other reasons clients may prefer to access their care through that door).

If purchasing were to shift to HCA as presented in Option 5 and be included in capitated managed care plans, a specialized plan of care must be designed for those individuals with complex behavioral health and/or medical needs. This could be achieved by way of a tiered payment rate based on complexity and risk, or a separate capitation rate for behavioral health or complex medical services. Whatever the method, the payment mechanisms need to adequately compensate for the care of higher need groups so that managed care plans won't try to discourage their enrollment. The plan must assure an appropriate benefit design for high need enrollees, one that coordinates with and includes linkages to services outside the Medicaid benefit such as housing, employment, wraparound services, etc. Safeguards would also need to be in place to discourage the managed care plans from shifting costs to hospitals, jails, homeless systems, and others. Regional-level entities may be an appropriate partner with the state to monitor utilization and trends in this area, and cultivate shared responsibility and accountability to assure that health outcomes are improved and costs controlled across the system—not just in the managed care plan. Finally, incentives should be considered that insure that the services/providers in the system that create health care cost savings benefit from those savings.

Whichever option is eventually implemented, it is important not to disrupt the current system until these and other issues can be addressed. The state must implement strategies that move the system in a rational, evolutionary way toward integrated care and financing in 2014 without dismantling or further fragmenting the system between now and then. The options did not provide a timeframe for the potential transfer of financing. Could any potential changes to the finance structure be delayed until the end of 2013? This would allow additional time for regions to organize and conduct further planning to support health care reform in 2014. Changing the financial structure now could remove any opportunity to do something different down the line.

Again, thank you for the opportunity to submit these comments.

Sincerely,

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